



TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC): PROVIDER ENROLLMENT

☐ Initial enrollment * ☐ Re-enrollment Provider PIN Number _____

*Contact the PHR in your area to obtain PIN

Name of Facility, Practice, or Clinic: _____

Provider Name (M.D., D.O., N.P., P.A. or C.N.M.*): _____
(Last Name) (First Name) (MI) (Title)

Contact: _____
(Last Name) (First Name) (MI) (Title)

Mailing Address: _____
(P.O. Box or Street Address) (City) (Zip)

Address for Vaccine Delivery: _____
(Street Address and Suite Number) (City) (County) (Zip)

Telephone Number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

E-mail Address: _____

In order to participate in the Texas Vaccines for Children Program and/or to receive federally and state-supplied vaccines provided to me at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural health clinic, or other organization, agree to the following:

- 1) Before administering vaccines obtained through the Texas Vaccines for Children Program (TVFC), my office will determine VFC eligibility. The Patient Eligibility Screening Form will be provided to the parent or guardian to declare each child's eligibility.
- 2) My office will maintain records of the parent/guardian/authorized representative's responses on the Patient Eligibility Screening Form for at least three years. If I use the Patient Eligibility Screening form as the sole source of documenting ImmTrac consent, I will maintain this record until the child has reached his/her 19th birthday. If requested, my office will make such records available to the Texas Department of Health (TDH), the local health department/authority or the U.S. Department of Health and Human Services.
- 3) My office will comply with the appropriate vaccination schedule, dosage, and contraindications, as established by the Advisory Committee on Immunization Practices, unless (a) in making a medical judgment in accordance with accepted medical practice, my office deems such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance with Texas Law, including laws relating to religious and medical exemptions.
- 4) My office will provide Vaccine Information Statements to the responsible adult, parent, or guardian and maintain records in accordance with the National Childhood Vaccine Injury Act. (Signatures are not required for the Vaccine Information Statements but are recommended.)
- 5) My office will not charge for vaccines supplied by TDH and administered to a child who is eligible for the TVFC.
- 6) My office may charge a vaccine administration fee. My office will not impose a charge for the administration of the vaccine in any amount higher than the maximum fee established by TDH. Medicaid patients cannot be charged for the vaccine, administration of vaccine, or an office visit associated with Medicaid services.
- 7) My office will not deny administration of a TVFC vaccine to a child because of the inability of the child's parent or guardian/individual of record to pay an administrative fee.
- 8) My office will comply with the State's requirements for ordering vaccine and other requirements as described by TDH.
- 9) My office or the State may terminate this agreement at any time for personal reasons or failure to comply with these requirements.
- 10) My office will allow TDH (or its contractors) to conduct on-site visits as required by VFC regulations.

(Signature*)

(Date)

*The TVFC Enrollment form must be signed by a licensed Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, Physician Assistant, or a Certified Nurse Midwife.